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ABSTRACT

The person with a borderline personality is considered to be neither neurotic nor psychotic, but to exist somewhere in between these two diagnostic categories. Psychoanalytic theorists who have researched the phenomenon of the borderline personality have shifted their emphasis away from Freud's instinct psychology and toward an ego psychology perspective. The Diagnostic and Statistical Manual of Mental Disorders-III lists eight specific symptoms of the borderline personality, of which at least five must be present to allow the diagnosis of borderline personality disorder: impulsivity or unpredictability in at least two potentially self-damaging areas; intense and unstable interpersonal relationships; inappropriate anger; identity disturbance; affective instability characterized by mood swings; intolerance of being alone; physically damaging acts; and chronic feelings of emptiness and boredom. Borderline personality disorders are generally global, affecting all areas of life. Patients with borderline personality disorders tend to blame others for their predicament; are often untroubled by their illness; and have rigid, inflexible, and maladaptive personality traits. This paper presents the psychoanalytic theory of borderline personality development, concentrating on the work of Kernberg and Masterson as perhaps being most representative of the new approach. The paper then goes on to present an Adlerian model of the borderline personality which takes the similarities with analytic theory into account. Conceptual differences that separate and differentiate the Adlerian model from psychoanalytic theory are also addressed. (NB)

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THE BORDERLINE PERSONALITY - AN ADLERIAN OVERVIEW.

by Leo Rattner, Ph.D.

A paper presented at
the annual N.A.S.A.P.
meeting, Philadelphia, PA.
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INTRODUCTION

When Alfred Adler died in May of 1937 in Aberdeen, Scotland, he left us a rich legacy. He gave us a psychology of understanding which was sufficiently flexible to allow us to comprehend normal as well as abnormal personality development. It also left room for further growth, since Adler was wise enough to realize that any science that would consider itself a finished product would quickly degenerate into a rigid, dogmatic structure. In order to be useful to society - which Adler surely valued as the highest goal he could aspire to - the science of the human mind that he had created would have to be open-ended and flexible enough to encompass findings from newer research without having to abandon the theoretical framework that comprised his Individual Psychology.

The subject of my presentation today is the borderline personality. This is a relatively new clinical and diagnostic concept that came into general use during the last two decades. Certainly, neither Freud nor Adler were aware of that clinical entity which we nowadays call the borderline personality. The entire spectrum of mental illness that they dealt with was comprised of the neuroses and the psychoses. And it was assumed in those early years when the founding fathers formulated their theories that a patient could have either one or the other mental illness, but not both. Yet it is one of the peculiarities of the

borderline personality disorder that a patient can have a brief psychotic episode without losing prolonged contact with reality. Hence the concept of the borderline personality, a person who is neither neurotic nor psychotic, but is located somewhere in between these two diagnostic categories.

Psychoanalytic theorists have done most of the research in the last two decades, trying to understand the phenomenon of the borderline personality. What is remarkable about their work is that is many cases there has been a pronounced shift away from Freud's instinct psychology towards an ego psychology. No longer is individual development viewed through the prism of sexual stages and the vicissitudes of the Oedipus complex. Rather, we can observe that the emphasis has shifted now to object relations, meaning the early relationship between mother and child. This, of course, brings such psychoanalysts closer to our own theoretical orientation, and makes their findings more accessible and also more acceptable to us.

In discussing the psychoanalytic theory of the borderline personality, I shall focus briefly on the work of Kernberg and Masterson as perhaps being most representative of the new approach. I shall try to elaborate their theoretical constructs that we can agree with, and also delineate where we have to disagree with their findings. I shall then try to present an Adlerian model of the borderline personality which will take the similarities with

analytic theory into account. But I shall also emphasize the conceptual differences that separate and differentiate us from present-day psychoanalytic theory. Because such a differentiation has important implications for the psychotherapeutic treatment of this most difficult patient population.

DIAGNOSTIC CRITERIA OF THE BORDERLINE PERSONALITY DISORDER

If we ask ourselves: "just what is a borderline personality?", then the answer is relatively simple. We can follow the diagnostic criteria which are spelled out in great detail in the DSM III. There are eight specific symptoms, of which at least five have to be present to allow the diagnosis of borderline personality disorder. As Adlerians we have no quarrel with the definition in the DSM III. But the relevant question for us is not only who is a borderline personality and what is a borderline disorder, but also why and what for? We want to know how such an emotional illness develops and how the individual tries to cope with it. On that score the DSM does not offer us much information, and we have to look elsewhere if we want to get meaningful answers.

Briefly, the diagnostic criteria are as follows:

1. Impulsivity or unpredictability in at least two areas that are potentially self-damaging; e.g. spending, sex, gambling, substance abuse, etc.

2. Intense and unstable interpersonal relationships characterized by marked shifts in attitudes.

3. Inappropriate intense anger, temper tantrums, chronic anger.

4. Identity disturbance leading to such questions as: "Who am I?"

5. Affective instability characterized by mood swings from normal to depressive, anxious or irritable.

6. Intolerance of being alone; depressed when being alone and frantic efforts to avoid being alone.

7. Physically damaging acts such as suicidal feature, self-mutilization, recurrent accidents or unprovoked physical fights.

8. And last but not least, chronic feelings of emptiness and boredom.

I am sure that all of you who work as clinicians have encountered quite a few patients who fit these diagnostic criteria. Because more and more of our patients seem to exhibit the personality traits and behavior patterns that are characteristic of a personality disorder. What we might add is that borderline personality disorders are generally global, affecting all areas of life. They are not confined to specific situations, such as work or interpersonal relationships. And in general there seems to be a lack of introspection, a difficulty to see oneself as contributing to his or her problems. Patients with borderline personality disorders tend to blame others for

their predicament. "Everybody is against me," or "No one really understands me," are frequently heard complaints during therapy sessions. What I have called "the urge to blame," is a prominent feature of borderline personalities.

Borderline personalities are often untroubled by their illness. They may see themselves as healthy, and other significant persons in their environment as being sick. Many of them never seek treatment, since they do not recognize that they have a problem. But if a borderline personality does get into therapy, the treatment process is bound to be difficult and frustrating. They have an uncanny ability to get under the skin of others, to irritate everybody, including the mental health professional. Prognosis for a successful outcome is therefore guarded at best, and failure of treatment is more common, for reasons that we shall discuss later on.

Finally, I want to point to another distinctive feature of borderline personality disorder, namely their rigidity. What Adler observed of neurotics, that they are characterized by rigidity and inflexibility, applies even more to borderline personalities. There, personality traits have become so inflexible and maladaptive that inevitably they cause significant impairment in social and occupational functioning as well as subjective distress. The borderline personality is - to use a poignant description by Waldinger (1986) like "a musician who can play only one note." Borderline personalities are caught in a prison

which they entered early in their lives, and from which they believe it is no longer possible to escape.

THE PSYCHOANALYTIC THEORY OF BORDERLINE PERSONALITY DEVELOPMENT

Sigmund Freud himself developed the concepts of primary and secondary narcissism which provided an important foundation for subsequent psychoanalytic theory about the narcissistic personality disorder. However, no such impetus about the borderline personality disorder came from the founder of psychoanalysis. Yet present-day psychoanalytic studies seem to be concerned with little else but this particular emotional illness. For the past two decades, there has been an abundance of books and articles dealing with various aspects of borderline development. What most of them seem to have in common is that they involve a modification of orthodox analytic theory as well as a modification of traditional psychoanalytic treatment techniques.

Kernberg (1975, 1989) tries to remain in the traditional psychoanalytic mold, even though he too acknowledges that borderline development is caused by traumas in the pre-Oedipal stage rather than during the Oedipal phase. Basically, Kernberg postulates that the fundamental difficulty for the borderline personality is an excess of aggression which frequently results from childhood

frustration. The child must defend himself or herself against these aggressive impulses through the mechanism of splitting. While splitting prevents the positive (or good) self from being overwhelmed by the negative (or bad) self, it also has some other unforeseen consequences. It weakens the ego and therefore reduces the individual's ability for adaptive functioning. Once the process of splitting has taken place, there is little capacity left for a realistic evaluation of others; the perception of significant others is permanently distorted. Still, Kernberg insists that the conflicts of the borderline personality are primarily internal, intrapsychic conflicts. While the basic logic of his theoretical position seems to lead away from traditional Freudian theory, Kernberg is reluctant to take the step that Kohut has taken and to come out for a basic revision of psychoanalytic theory.

Masterson (1988), on the other hand, seems less encumbered by traditional analytic theory than Kernberg. He, too, focuses on the first three years of life as the breeding ground for future borderline personality development. But he focuses more specifically on deficiencies in mother-child interaction as the primary cause for such development. When the child experiences feelings of rejection and is afraid of abandonment during this period, then - according to Masterson - it shuts down the real self, in order to avoid aggravating feelings of abandonment. This leads to an arrest of further psychological

development and produces varying degrees of impairment in the individual self.

Masterson argues that under normal conditions the real self and its capacities can emerge, allowing the child to mature into an autonomous adult capable of self-actualization. The child that has progressed through the proper developmental stages and successfully achieved separation and individuation, is capable of impulse control, can tolerate frustration and has stable ego boundaries. Conversely, the child that has not been able to progress through these stages, experiences developmental arrest in terms of the real self and its ego functions. It will continue to rely on primitive defense mechanisms, such as denial, clinging, distancing and acting out behavior. Masterson, too, recognizes splitting as the basic defense mechanism of the borderline personality. But he makes the interesting distinction that the good self image is linked to the good mother image, while the bad, inadequate or deflated self image is linked to the bad mother image.

Both Masterson and Kernberg advocate modifications of traditional analytic technique in dealing with borderline patients. Their basic approach is a far cry from the stance that Freud suggested, when he recommended that the analyst should adopt the cold, detached attitude of the surgeon when dealing with a patient in analysis. Both Kernberg and Masterson emphasize the need for warmth and empathy in the treatment of the borderline patient, though

Kernberg advocates a more confrontational stance than Masterson seems to do. Both recognize that such patients may need supportive therapy for a long time, before traditional analytic therapy can be attempted. But Masterson seems to be the more optimistic therapist as far as the chances of successful treatment are concerned. And he also seems closer to our own theoretical position, putting more emphasis on the need for social relatedness of the patient and the need for some tangible success in the patient's personal life than does Kernberg.

Masterson is more emphatic on the need for supportive therapy. He argues that because of the developmental arrest, part of the patient's personality has been left in a closet. The patient has never learned to recognize what he wants, to identify what he is really interested in, be it a career, a hobby or a relationship. The therapist, says Masterson, deals with this immaturity by providing a learning experience through communicative matching responses which also often serve as confrontations with reality. Such confrontations may appear as obvious and commonsensical to the average adult who has learned it from experience. But these responses are not obvious to the patient. The ego of the borderline patient, Masterson asserts, is perforated with holes. It is therefore the task of the therapist to plug these holes and to provide the patient with a more complete and solid perception of reality.

What is striking about these formulations is how much they owe to Adler without acknowledging the original source. Masterson, in particular, speaks of an inadequate ego, the discouragement of the borderline person, the need for social relatedness and the necessity of imparting common sense to the patient. What is lacking from our point of view, however, is the integrative concept of social interest which provides an overall framework for understanding dysfunctional personality development. And both Masterson and Kernberg fail to ask the obvious question: why there are so many more borderline personalities in our time than at the time when Freud, Adler and Jung practiced their craft? While it is evident to an Adlerian that social and economic conditions that prevail in our society have an enormous impact on personality development, such factors may not be so evident to psychoanalysts who have not learned to take into account the larger social environment in which individual development takes place.

AN ADLERIAN CONCEPTION OF THE BORDERLINE PERSONALITY

As Adlerians we are trained to view a person holistically. We tend to focus not on isolated symptoms, but rather want to consider a whole range of connected personality traits and behavior patterns. Therefore, as far as the borderline personality is concerned, we would try to

find a cluster of symptoms that show an organic connection. In particular, I have in mind the symptoms of unstable relationships, emotional instability, intolerance of being alone and a pervasive sense of emptiness and boredom. What these symptoms tell me is that here is a person who lacks adequate socialization, an individual who has not been able to develop his latent capacity for social interest. This is the foundation out of which the borderline personality grows and develops.

Adler is quite specific on that point. In one of his later books he writes:

> Wherever I have studied adults, I have found impressions left on them from their early childhood and lasting forever. The position in the family leaves an indelible stamp upon the style of life. Every difficulty of development is caused by rivalry and lack of co-operation in the family (1932, p.154).

Children who are prone to become borderline personalities in later life are children who are rejected, neglected or abandoned, and especially children who have been abused physically, emotionally and sexually. This is a pervasive problem in our society, and it seems to be getting worse rather than getting better. The disintegration of the family is a fact of life in our inner cities. Divorce and desertion have left many mothers alone with the task of caring for their children. All the problems resulting from such a situation are exacerbated by poor housing, discrimination and lack of intellectual and cultural stimulation for the children.

Such families are often living on the edge of panic,

and it is not surprising that the children who are forced to grow up under such conditions are severely damaged emotionally. Witness a recent article in The New York Times (Feb. 12th, 1990), which describes graphically the dysfunctional lives of many young inner city children. The realities there are : "crack-addicted mothers, sexually abusive fathers and gunfire a nightly ritual." The consequences of such a situation are - according to one counselor - "children having children, students attempting suicide and girls dating married men." And another counselor observed matter of factly: "We have parents lost to crack or AIDS, children living in temporary shelters. Depression is very high in our school system." It does not take much ingenuity to realize that these conditions create and foster an atmosphere out of which antisocial and borderline personalities develop.

But it would be a mistake to assume that only poor and broken families are the breeding ground for borderline personalities. The phenomenon is also present in middle-class families which seem outwardly intact but are inwardly like empty shells. There it can be observed that parents give their children all the material things, but they rarely give of themselves. Such parents are lacking in emotional warmth; they are cool and detached from themselves and from their children. As Lash (1980) has pointed out, they are more concerned with making it for themselves in our society rather than making it with their children.

Their own success is more important to them than the emotional health of their children. Despite the material privileges these children enjoy, their lives are frequently characterized by feelings of emptiness, boredom, depression and anxiety, and above all by the fear of being alone.

All this is not difficult to understand. The children realize that they are useless to their parents. Therefore, they feel worthless and profoundly discouraged about their ability to function competently in life. To compensate for these feelings of inadequacy, they often look for thrills and excitement which should confirm to them that they still exist, that they are still alive. Such tendencies are aided and abetted by the media, particularly radio with its incessant noisy music which drowns out any possibility of rational thinking, and T.V. with its mindless sitcoms and its rationalization of senseless violence. Wherever one looks today, we see that many of our children are endangered because we have not been able to create the social and economic conditions that would help to foster an environment in which emotionally stable and healthy children can grow and develop.

The consequence of such a situation is that borderline personalities are becoming increasingly common. As Adlerians we recognize that this severe emotional disturbance is based on an exacerbated feeling of inferiority. The individual who becomes a borderline personality feels basically weak, worthless and powerless, and is desperately

trying to hide the reality of these feelings from himself and the world. While the neurotic generally succeeds in one or more of the life tasks, the borderline personality will usually fail in all three tasks of life. The borderline symptomatology is an attempt to evade the reality of this situation by trying to find an appropriate rationalization; namely, that the world must be blamed and that the individual cannot be held responsible for failure to come to terms with his existential predicament.

PSYCHOTHERAPY OF THE BORDERLINE PERSONALITY

Even though many of us have undoubtedly worked with borderline patients over the last few decades, there are unfortunately not many reports available to us which would indicate an Adlerian treatment approach to this mental illness. As a matter of fact, I know of only one such report by James Croake which appeared in a recent issue of our journal Individual Psychology. There Croake describes his treatment of a borderline patient in some detail, giving us verbatim excerpts and running commentaries on some of the dramatic highlights he encountered in his 45 sessions with a 26 year old female patient. Croake used a cognitive, confrontational style in his work with this patient, and evidently had some success in achieving a measure of reality orientation with this young woman. But at the end of his article he leaves no doubt that working

with such patients is extremely difficult and frustrating, and that after 45 sessions the real therapeutic work lies still ahead. Progress with borderline patients is frustratingly slow and has to be measured in inches, rather than in feet or yards. From my own experience in working with such patients, I believe that psychotherapy with borderline patients is always a long-term commitment, that there are no shortcuts available, and that the treatment process generally lasts not a few months but several years, and sometimes even more than a decade.

Another merit of Croake's article is the fact that we get a strong indication of how difficult it is for the therapist to work with borderline patients. It is almost impossible at the beginning to establish a therapeutic alliance with such patients; they are always resistant and are constantly trying to frustrate and to defeat the best efforts of the therapist. Croake got some support in his work with the young female patient from a co-therapist. But such a solution is not always possible and frequently not even desirable. While it may be helpful to the therapist, it may complicate matters for the borderline patient who usually has already great difficulty with a one to one relationship.

Just how difficult therapy with borderline patients can be[15] expressed succinctly by Waldinger. In his book "Fundamentals of Psychiatry," he writes:

> People with personality disorders are notoriously difficult to treat. Their pathological ways of dealing with the world are deeply ingrained, yet they act as if the problem lies with the world and not with them. They are often angry, demanding and abusive toward therapists, and have an extraordinary capacity to home in the weaknesses and vulnerabilities of those who try to help them. They will attempt to form the same type of pathological relationship with you that they form with others in their lives. They are generally reluctant to see their behavior as a problem and are likely to blame you when their wishes are not fulfilled in therapy (p. 178).

The reasons for the difficulties in treating such patients are varied, and I can enumerate only some of them in the context of this paper. First and foremost is the suspicious, distrustful attitude of borderline patients. They distrust everyone, and the therapist is no exception to this basic approach towards other people. In some ways we can even say that such suspicion and distrust are justified, because many borderline patients have been abused physically, emotionally and sexually in early childhood. Their experience has taught them not to trust anybody, and this is the attitude that they bring initially to psychotherapy as well.

The specific kind of resistance in which this attitude manifests itself is a stance of "show me"' meaning: "prove to me that I can trust you." The borderline patient will constantly test the therapist, and the tests are set up in such a way that the therapist is bound to fail most of them. The patient is prosecutor, judge and jury all in one. He or she can always decide whether the therapist

passed or flunked the test. And after failing such a test, the patient is likely to attack the therapist even more with the frequently voiced complaint: "You really don't care for me. Nobody does."

In this context I can remember a patient of mine who after several years of psychotherapy was in an extremely resistant phase where he constantly attacked me for not being competent enough, not being trustworthy, not really caring for him. Being young and relatively inexperienced in dealing with borderline patients at that time, I expressed surprise that after all these years of therapy he still distrusted me. The patient came back spontaneously with the statement: "Don't you understand that I am talking about myself; that I really hate myself and cannot believe that anybody could really like me." It was a powerful lesson that I learned from this statement; a lesson that I have never forgotten and which sustained me in many difficult, frustrating periods of working with borderline patients. Because the testing of the therapist serves indeed an important purpose. The patient is trying to establish whether the therapist can take his hostility and not reject him for it. If it could be verbalized, the reasoning would go like this: "If the therapist cannot deal with my anger and rage, how can I expect others to do so?" Yet anger and rage are an integral part of the borderline personality, and the therapist's office must serve as a laboratory where appropriate ways of channeling and

expressing that anger can be tested and validated.

Almost 100 years ago, the philosopher Nietzsche wrote: "Beware of the resentment of those who feel shortchanged by life." Nietzsche did not know of borderline personalities, and he might be surprised if he were alive today to realize how many such people exist and how much resentment is generated by them. Envy, resentment and hostility are characteristic of borderline personalities, and these feelings are directed towards everyone and everything. Underlying this worldview is the rationalization: "nothing good will ever come my way; so why should I have positive feelings for anyone?" It is in many ways a self-fulfilling prophecy. Since the borderline person approaches the world with a hostile, belligerent attitude, he or she is likely to get a response that confirms the basic feeling that the world does not care.

A characteristic feature of borderline personalities is the inability to be alone. This, I would suggest, has to do with the fact that the borderline person cannot be alone with himself or herself. There is a great deal of self-hatred involved in this kind of pathology. Borderline patients have generally been rejected or abandoned very early in life. From this experience they have drawn the conclusion that nobody cares for them, that everybody hates them. Or as one female patient once explained to me: "You must be disgusted with me, just like everybody else." The perceived hatred of the parents is projected back unto

the outside world. And a rationalization is found which ultimately protects the parents, since the patient acknowledges that she is disgusting and therefore should be rejected.

When I discussed earlier the Adlerian model of the borderline personality, I mentioned the inadequate socialization, the failure to activate the potential for social interest in early childhood. Clearly, this points to a failing on the part of the mother to fulfill her primary function, to be a bridge to social life for the child. The issues this presents for psychotherapy are evident to an Adlerian therapist. We must help the patient to compensate for this deficiency, we must help him or her to develop the latent capacity for social interest. Psychotherapy consists of two parts. On the one hand, we help the patients to gain insight into their life-style and personality development, help them to understand their fictitious goals and how their private logic and biased apperception inevitably create difficulties for them in the outside world. On the other hand, we focus on the relationship with the therapist, because it is in the therapist's office that the maladaptive behavior patterns are clearly manifested. And it is in the interaction with the patients that we can educate them to the value of cooperation, that we can teach them through our attitude and behavior that we do care for their welfare, and that we are genuinely committed to assist them in their struggle for a

better life.

The psychotherapist, therefore, has to be a person with a mature social interest. This, I believe, is self-understood by any Adlerian. But I want to emphasize how particularly important it is when working with borderline patients. Such patients demand a great deal from us. They test not only our professional skills but our social interest as well. Just how long can we remain caring and concerned for this person who gives so little to therapy, who often fights us every inch of the way? And yet, this is precisely the challenge we must meet in the treatment of the borderline patient. We have to demonstrate through our attitudes and behavior that social interest does indeed exist, and that we continue to care for this person, even if he or she does not seem to care for themselves. And in trying to convey the reality of social interest, we must at the same time be careful to maintain a fine balance between showing caring for the patient and setting limits to his or her destructive behavior. I realize that I have given you only a sketchy outline of the issues that are important in the treatment of the borderline personality. But let me conclude this section with some don't and do's that play a significant role in the treatment process. First, I would emphasize that you don't argue, don't fight and above all don't criticize borderline patients. They are extremely sensitive, and will inevitably construe such behavior on your part as a hostile act. Secondly, don't take over the

management of their lives. Borderline patients will plead, be seductive, do everything they can think of to get you to assume responsibility for their financial affairs and their interpersonal relationships. To do this is, of course, counterproductive in any therapy. But it is especially harmful in working with borderline patients because it reinforces an existing tendency to become overly dependent, to overidealize the person who helps them initially and then to devaluate that person when there is less than total success in the joint undertaking.

What you can and should do is encourage them in a moderate and realistic way. Whenever you see signs of positive actions and behavior it should be emphasized that this represents tangible progress for the patient. This is important because the borderline patient is generally deeply pessimistic and demoralized. But precisely because it is such an important issue, it is essential that encouragement be based on concrete indications. If the patient is praised for something he or she cannot experience emotionally, then they will feel that they are being patronized or worse, being lied to. And we already know how suspicious borderline personalities are, and how likely they are to believe that the world is out to deceive them.

Perhaps it is appropriate here to add a few words about the qualities which I believe are necessary for the psychotherapist who wants to work with borderline patients.

First and foremost among these are patience and perseverance, because progress with borderline patients is so painfully slow. Secondly, one needs a sense of humor and an awareness of one's own fallibility. We should not expect or demand of ourselves perfection. It is difficult enough if the patients demand perfection from us, as they are frequently apt to do. And ultimately we need a sense of humility which Adler prescribed as the proper stance for all therapeutic endeavors. We are not Godlike; we must always keep in mind that we can only help the patient to the extent that he or she are capable and willing to help themselves. To gain the cooperation of the patient, to be able to establish a therapeutic alliance is the basic supposition for therapeutic success.

Finally, if you find that working with a particular borderline patient becomes too difficult for you, if you wish to terminate treatment because you are discouraged, don't give in to that temptation without first trying to get some help for yourself. Talk to colleagues and especially to older therapists who may have more experience than you in working with such patients. They may help you to overcome your frustrations and your feelings of impotence. And they may point out some subtle indications of the patient's progress that you could not see because of your own distress. Remember that the borderline patient has already experienced a great deal of rejection in his life. To be rejected by the therapist as well would be the

ultimate confirmation that everybody is against him or her, and that the world really hates him. To confirm that piece of private logic is something that only the most extreme circumstances could justify.

SUMMARY AND CONCLUSIONS

Borderline conditions and other personality disorders are rapidly becoming the major mental health problem of our time. That development was anticipated more than fifty years ago by Karen Horney when she noticed the emergence of a new personality type. She described the dominant features of this type as competitiveness, envy, greed and hostility. And in a break with psychoanalytic orthodoxy, she no longer ascribed these problems to intrapsychic conflicts but rather saw them as being caused by a society and culture that sends out confusing and conflicting messages to the individual. And in a telling phrase, she called these forerunners of modern-day personality disorders the "stepchildren of our culture."

Horney, of course, reiterated only what Adler had said many times before her; that the breakdown of the traditional family structure was causing not only social problems but emotional problems as well. And while Adler realized early that the lack of social interest causes mental health problems, he was also aware at the same time that many mothers were no longer able to fulfill their traditional

function of properly socializing the child. From the beginning, therefore, Adler was as much concerned with prevention as with a cure. One of the first pamphlets he ever wrote is titled "The Physician as Educator," and in it he clearly stated that prevention is a primary task of the mental health professional. To that end he created the first child guidance clinics in Vienna with the aim of helping the child to become properly socialized before discouragement and neurotic development could become embedded in the child's personality and life-style.

Looking at the contemporary scene, we have to realize that much more needs to be done along these lines. Now that the cold war is over, we must work for a fundamental change in our social policy. Much of the resources from the peace dividend should be devoted to the strengthening of the family. We need more and better education, more headstart programs, more programs to strengthen the basic family structure. And while we must be concerned with teaching our children the three R's so that they can minimally function in this world, we also need to create conditions that will foster and encourage the development of social interest. If the motto for the coming decade is : "Let us give peace a chance," then we must amend it with the additional demand: "Let us also give social interest a chance." As Adlerians we are convinced that one cannot succeed without the other.

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